AMERITAS GROUP
We're Ameritas. We're for people.℠
A Division of Ameritas Life Insurance Corp.
A UNIFI Company

P.O. Box 81889
Lincoln, NE 68501
800-659-2223
Fax 402-467-7338

Vision Employee Enrollment & Waiver - TN

Company name	Account number	Department/Division
WILLIAMSON COUNTY	010-350679	N/A

Employee Information

Name			Social security number	
Mailing address (street)			Birth date	☐ male ☐ female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? ☐ Yes ☐ No	
Date employed full-time	Hours worked per week		Employer ZIP 37064	Employer county WILLIAMSON

Vision

☐ **Elect** ☐ **Decline**	Employee	Employee + 1 Dep	Family
Monthly premium	$9.62	$18.02	$27.50
Benefit election – check box	☐	☐	☐

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	☐ male ☐ female	Social security number	
Name(s) of child(ren)	Birth date	☐ male ☐ female	Social security number	☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Employee Signature (Read and sign below.)

I understand and agree with the following statements:

- I agree that I must stay enrolled at least one year from the effective date of coverage unless my employment is terminated.
- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse coverage, I cannot enroll after retirement.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage. I agree Ameritas Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
- I authorize Ameritas Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Ameritas Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by Ameritas Life only as allowed by law.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Ameritas Life.

Your signature X_____ **Date Signed** _____